



RSC Policy Brief: Insurance Benefit Mandates

September 22, 2008

The RSC has prepared the following policy brief analyzing the impact of benefit mandates on health insurance markets.

Background: Since the 1960s, state legislatures have considered—and adopted—legislation requiring health insurance products sold within the state to cover various products and services. These benefit mandates are frequently adopted at the behest of disease groups advocating for coverage of particular treatments (e.g. mammograms) or physician groups concerned that patients have access to specialists' services (e.g. optometrists).

A recent survey by the Council for Affordable Health Insurance found that as of 2007, states had enacted a total of 1,961 mandates for benefits and services—an increase of 60 (more than one per state) when compared to the 2006 total.¹ The number of state mandates varies from a low of 15 in Idaho to a high of 64 in Minnesota. However, because employer-sponsored health insurance is pre-empted from state-based laws and regulations under the Employee Retirement Income Security Act of 1974 (ERISA), benefit mandates do not apply to employers who self-fund their health insurance plans; thus state mandates primarily affect policies purchased in the individual and small group markets.

Costs and Impact on Take-up Rates: The cost and impact of benefit mandates on health insurance premiums have been the subject of several studies in recent years. For instance, the Heritage Foundation prepared an analysis suggesting that each individual benefit mandate could

¹ Council for Affordable Health Insurance, "Health Insurance Mandates in the States 2008" and "Health Insurance Mandates in the States 2007," available online at http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf and http://www.cahi.org/cahi_contents/resources/pdf/MandatesInTheStates2007.pdf, respectively (accessed July 19, 2008).

raise the cost of health insurance premiums by \$0.75 monthly.² Although the cost of a single mandate appears small, the aggregate impact—particularly given the recent growth of benefit mandates nationwide—can be significant: For instance, Massachusetts' 43 benefit mandates would raise the cost of health insurance by more than \$30 monthly under the Heritage analysis.

In July, the Commonwealth of Massachusetts released its own study on the impact of state benefit mandates, which was compiled as a result of the health reform law enacted under Gov. Mitt Romney. The report found that in 2004-05, spending within the Commonwealth on mandated benefits totaled \$1.32 billion—or 12% of health insurance premiums—prior to the introduction of a prescription drug benefit mandate likely to increase premium costs further.³ Because some of these benefits (e.g. diabetes coverage) likely would have been provided even in the absence of the state mandate, the report calculated that the marginal costs of the mandates could range as high as \$687 million—or more than 6% of health insurance premium costs.⁴ The report also noted that some benefit mandates, such as those requiring bone marrow transplants for breast cancer, are ineffective, in part because the mandated benefits no longer match the recommended standard of care, and went on to recommend an ongoing review of the necessity of mandated benefits.⁵

A further level of analysis on the impact of higher premium costs, specifically those associated with benefit mandates, on the number of uninsured Americans, finds some correlation between the costs related to benefit mandates and rising numbers of uninsured. Some estimates suggest that every 1% increase in premium costs has a corresponding increase in the number of uninsured by approximately 200,000-300,000 individuals nationwide.⁶ Because rising costs are associated with the introduction of a specific new benefit, the price elasticity associated with the mandate will tend to vary based on the benefit's perceived usefulness—for instance, a single 20-year-old would be more likely to drop coverage if an infertility benefit mandate increased premium costs than would a married couple trying to conceive. However, based on the studies above, it is reasonable to say that likely several hundred thousand, and possibly a million or more, Americans could obtain coverage if unnecessary benefit mandates were eliminated—and millions more Americans currently with insurance could receive more cost-effective coverage.

Legislative Proposals: Various legislative provisions introduced in current and prior Congresses attempt to reform state benefit mandates through a variety of mechanisms. The

² Michael New, "The Effect of State Regulations on Health Insurance Premiums: A Revised Analysis," (Washington, Heritage Center for Data Analysis Paper CDA06-04, July 25, 2006), available online at http://www.heritage.org/Research/HealthCare/upload/CDA_06-04.pdf (accessed July 19, 2008), p. 5.

³ Massachusetts Division of Health Care Finance and Policy, "Comprehensive Review of Mandated Benefits in Massachusetts: Report to the Legislature," (Boston, July 7, 2008), available online at http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/mandates/comp_rev_mand_benefits.pdf (accessed July 19, 2008), p. 4.

⁴ Ibid., pp. 5-6.

⁵ Ibid., p. 6.

⁶ See, for instance, Todd Gilmer and Richard Kronick, "It's the Premiums, Stupid: Projections of the Uninsured through 2013," *Health Affairs* Web Exclusive April 5, 2008, available online at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.143/DC1> (accessed July 19, 2008), and Government Accountability Office, *Impact of Premium Increases on Number of Covered Individuals is Uncertain* (Washington, Report GAO/HEHS-98-203R, June 11, 1999), available online at <http://archive.gao.gov/paprpdf/160930.pdf> (accessed July 19, 2008), pp. 3-4.

Health Care Choice Act (H.R. 4460) by Rep. John Shadegg (R-AZ) would permit individuals to purchase health insurance plans across state lines, which would give individuals living in states where benefit mandates have driven up the cost of insurance the opportunity to purchase more affordable policies. The legislation could have the secondary benefit of encouraging states to avoid imposing new mandates and to re-think their current mandates, so as to make their policies more affordable and attractive to the citizens of their state—who otherwise may take the new opportunity to purchase coverage elsewhere.

Other options to reform state benefit mandates include Association Health Plans (AHPs) and Individual Membership Associations (IMAs), which would allow small businesses and individuals respectively the opportunity to band together to purchase health insurance. In so doing, the associations would be exempted from state-based laws regarding mandated coverage of particular services or diseases. Some conservatives may believe that these types of association plans may deliver value as a result of the pre-emption of the often costly benefit mandates.

A third option, first proposed by Sen. Judd Gregg (R-NH) in a 2004 Senate report and recently drafted into legislative language by Rep. Jeff Fortenberry (R-NE) as H.R. 6280, would require states to permit insurance carriers to offer mandate-free policies alongside their existing menu of coverage options. As a result, consumers could choose whether to purchase a plan that offers richer coverage or a plan that might offer better value by targeting the type of benefits provided. Some states, most recently Florida, have already taken steps in this line, passing legislation permitting lower-cost policies that may not offer the full menu of mandated benefits; Massachusetts offers such policies, but only to young adults aged 19-26.

Conclusion: Although the types of benefit mandates imposed by states can vary from the duplicative (e.g. cancer coverage already provided by virtually all plans) to the costly (e.g. in vitro fertilization) to the frivolous (e.g. hair prosthesis), some conservatives may view them collectively as a failure of government. In some respects, behavior surrounding state benefit mandates represents a case of moral hazard, whereby benefits (to particular disease or provider groups) are privatized, while costs—in the form of higher insurance premiums—are socialized among all payers. Although some states have acted recently to study the cost effects of imposing so many benefit mandates, or to offer mandate-free or “mandate-lite” health insurance options to their citizens, the allure of appealing to a particular constituency group—as opposed to the interests of all individuals whose premiums will increase upon imposition of a mandate—often proves too difficult for policy makers to resist.

Although well-intentioned, some conservatives may view the groups who advocate for benefit mandates as operating from fundamentally flawed logic: that individuals ***should go without health insurance entirely*** rather than purchase coverage lacking the “consumer protection” of dozens of mandates. In addition, some conservatives note that the prospect of increasing the number of uninsured through such methods may precipitate a “crisis” surrounding the uninsured, increasing calls for a government-run health system. In short, many conservatives may believe individuals should have the “consumer protection” ***to*** purchase the insurance plan they desire—rather than the “protection” ***from*** being a consumer by a government which seeks to define their options, and raise the cost of health insurance in the process.

For further information on this issue see:

- [*Council for Affordable Health Insurance: Health Insurance Mandates in the States 2008*](#)
- [*Heritage Report: The Effect of State Regulations on Health Insurance Premiums*](#)
- [*Comprehensive Review of Mandated Benefits in Massachusetts*](#)

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